FOR OFFICE USE ONLY
Application Approved:
License Number:
Issue Date:
Grad/Temp License #:
Issue Date:
Signature of Board Administrator
ID#:
Receipt #:

Rhode Island
Board of Licensure of Physician Assistants

Room 205
3 Capitol Hill
Providence, RI 02908-5097

Instructions and Application For
License As A
Physician Assistant
by

☐ **Examination**

Graduate Status ☐ **Yes** ☐ **No**

☐ **Endorsement**

☐ **FCVS** (See instructions on page 2)

Applicant - Print Name (First/MI/Last)

☐ I am also applying for a RI Uniform Controlled Substances Registration (CSR) and I have attached the CSR application to this license application.

Phone: (401) 222-3855 **TTY/TDD: (800) 745-5555** **Fax: (401) 222-2158**

Revised 03/31/2006 awp

GENERAL INFORMATION

Enclosures

The following materials and information should be enclosed within this application packet:

Licensure Requirements

Applicants

1. Fee of **$62.50** (or **$162.50 with CSR**) NOTE: These application fees are **NON-REFUNDABLE**.
2. Recent passport type photograph.
3. License Verification(s) from the state(s) in which applicant holds or has held a license.
4. Official transcript from an accredited School of Physician Assistants.*
5. Score/Certification sent directly from the National Commission on Certification of Physician Assistants (NCCPA).*

***FCVS**

IMPORTANT: *If applicant provides verification of credentials by the **Federation Credentials Verification Service (FCVS)** of the **Federation of State Medical Boards (FSMB)**, requirements 4 and 5 above shall be met and said documentation need not be submitted. An application for verification of credentials by FCVS may be obtained by contacting the Federation of State Medical Boards, toll free at **1-888-ASKFCVS** (1-888-275-3287), or it can be downloaded at the Federation's web site at:*

http://www.fsmb.org/fcvs_physicianassistant.html

Graduate Status

***Note:** refer to Section 6.9 of the Rules and Regulations (web link below), entitled "Graduate Practice" to determine whether you are eligible to apply for Graduate Status.*

- Requirements listed under "Applicants" (above) with the exception of scores from NCCPA. Foreign-educated graduates are not eligible for Graduate Status
- Application for graduate status must be filed within 30 days of date of graduation. Graduate status permits are issued for a period of 90 days and may not be renewed. **Failure to pass the certification examination results in the revocation of a graduate status permit**.

Rules and Regulations

The rules and regulations for licensing "Physician Assistants" can be obtained at the Board web site:

http://www.health.ri.gov/hsr/professions/phys_assist.php

NOTE: ALL physician assistant applicants must have a supervising physician who oversees the activities of, and accepts the responsibility for, the medical services rendered by the physician assistant

APPLICATION PROCESS OVERVIEW

The licensure process in the State of Rhode Island is conducted by the Rhode Island Department of Health (HEALTH), Office of Medical Licensure & Discipline, and the Rhode Island Board of Licensure of Physician Assistants (Board).

Application Process

In addition to the application, you must submit additional information directly to the Board. All items listed on the "checklist" (page 9) must be submitted for an application to be considered complete. All applications are considered valid for 1 year from the day they are received at HEALTH. If you do not complete the application process and obtain a license within 1 year a new application must be submitted.

Please allow a minimum of 4-6 weeks for the entire licensure process to be completed. If you have malpractice criminal or disciplinary history, in Rhode Island or another state, it can take an additional 2 or 3 months for all pertinent documentation to be received, and a decision to be made regarding issuance of your license.

Licenses will be issued within 7-10 working days following approval of the license. Wallet-sized license cards are mailed within 3 weeks from the date of issuance, and are mailed to the address furnished in the application. You are responsible for notifying the Board office, in writing, if your address changes in the interim. The Board may be emailed an address change. The email address is located at the following web site.

http://www.health.ri.gov/hsr/professions/phys_assist.php

To obtain your license number prior to receiving your license card, please refer to the HEALTH Licensee Lookup web site:

http://www.health.ri.gov/hsr/professions/license.php

HEALTH will not, for any reason, accelerate the processing of one applicant at the expense of others. Once completed, the application will be reviewed, and you will be contacted in writing.

Please continue to review the remaining portions of this application packet for instructions and other materials necessary to complete the application.

It is the responsibility of the applicant to arrange for submission of ALL licensure requirements. HEALTH does NOT notify applicants of missing or incomplete documentation.

If you have any questions about this application process, or would like to check on the status of your application, please contact the board staff at (401) 222-3855.

INSTRUCTIONS FOR COMPLETING THE LICENSE APPLICATION

Read the following instructions and those throughout the application packet carefully before completing the application. **Only complete applications with the appropriate fee will be accepted.** Failure to submit all required information and appropriate documentation may result in processing delays.

General Instructions

1. Make a copy of the application and forms before you begin in case you make a mistake.
2. Type your information or print in blue or black ball-point pen. HEALTH staff will not make assumptions about illegible information.
3. Provide a response to each section or question; otherwise mark "N/A" for Not Applicable.
4. We suggest that you make a copy of your completed application before submitting it to HEALTH.
5. It is your responsibility to check on the status of your application.

Completing your Application

1. Complete the application (pages 5-8). You must respond to all components of the application as instructed. If you attach separate pages in continuation of the application, such pages **MUST** clearly indicate the section for which such information is being reported.

2. Make check or money order (in U.S. funds only) for the application fee of **$62.50** (or **$162.50 with CSR**) payable to **Rhode Island General Treasurer** and staple it to the upper left-hand corner of the first (Top) page of the application. This application fee **CANNOT BE REFUNDED,** even if the applicant is found ineligible for licensure.

3. Affix a recent **2 X 2 photo** of yourself in the space provided.

4. A completed official transcript **sent directly** from the accredited school of **Physician Assistants** to the Board of Licensure of Physician Assistants (Address below)- OR **FCVS**. No student copies will be accepted.

5. If you are a new graduate and applying for Graduate Status and your transcript is not yet available, a certified statement may be **sent directly FROM** the Dean or Registrar of the Physician Assistant Program verifying your completion of **ALL GRADUATION REQUIREMENTS**, A completed official transcript must be **sent directly FROM the school** to the Board of Licensure of Physician Assistants as soon as it is available. A license cannot be issued without receipt of an official transcript.

6. Scores, or certification, **sent directly** from the **NCCPA (Telephone 1-678-417-8100)** to the Board of Licensure of Physician Assistants, OR **FCVS**.

7. RI Uniform Controlled Substances Act Registration Form (CSR) if applicable (page 11.).

8. **(Endorsement Candidates):** Please send the license verification form on page 10 to all states in which **applicant** holds or has held a license. Be sure to sign and complete the identifying information on the form. HEALTH must receive these verifications **directly** from the licensing authority in each state.

9. A completed "Mandatory Addendum to License Application" (verification of Social Security Number) form.

10. Mail the application and documentation to:

Rhode Island Department of Health
Board of Licensure of Physician Assistants, Room 205
3 Capitol Hill
Providence, RI 02908-5097

State of Rhode Island
Board of Licensure of Physician Assistants

Application for License as a Physician Assistant

Refer to the Application Instructions when completing these forms. Type or block print only. Do not use felt-tip pens.

1. Name(s)

This is the name that will be printed on your License/Permit/ Certificate and reported to those who inquire about your License/ Permit/ Certificate. Do not use nicknames, etc.

Title (i.e., Mr., Mrs., Ms., etc.)

First Name

Middle Name

Surname, (Last Name)

Suffix (i.e., Jr., Sr., II, III)

Maiden, if applicable

Name(s) under which originally licensed in another state, if different from above (First, Middle, Last).

2. Social Security Number

U.S. Social Security Number

Please Refer to "Mandatory Addendum to License Application" on the last page of this application

3. Gender

☐ Male ☐ Female

4. Date and Place of Birth

Month Day Year 1 9

City and State; **OR** Province and Country, etc., if NOT U.S.

5. Home Address

It is your responsibility to notify the board of all address changes.

1st Line Address (Apartment/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City State Zip Code

Country, If NOT U.S. Postal Code, If NOT U.S.

Home Phone Home Fax

Email Address (Format for email address is Username@domain e.g. applicant@isp.com)

6. Business Address (ONLY if it is RELATED to your license.)

It is your responsibility to notify the board of all address changes.

This address will appear on the Department of Health web site.

Name of Business/Work Location

1st Line Address (Department/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City State Zip Code

Country, If NOT U.S. Postal Code, If NOT U.S.

Business Phone Extension Business Fax

Applicant: Print your complete last name >

7. Preferred Mailing Address

Please check ONE

☐ Please use my **Home Address** as my preferred mailing address

☐ Please use my **Business Address** as my preferred mailing address

8. Qualifying Education

Please list the name and information about the school that you attended that qualifies you for this license.

Type of School (University, College, Technical School, etc.)

Name of School

Date Graduated: Month Year

Degree Received (Bachelor of Arts, Master of Science, Diploma, etc.)

9. Other State License(s)

Please answer the question and list state(s), if applicable

Have you ever held, or do you currently hold, a license in another state? ☐ Yes ☐ No

If the answer to this question is ***"yes"***, enter all other state licenses in Question 10 (below):

10. Licensure

List all states or countries in which you are now, or ever have been licensed to practice your profession.

State/Country:			State/Country:		
________________	☐ Active	☐ Inactive	________________	☐ Active	☐ Inactive
________________	☐ Active	☐ Inactive	________________	☐ Active	☐ Inactive
________________	☐ Active	☐ Inactive	________________	☐ Active	☐ Inactive
________________	☐ Active	☐ Inactive	________________	☐ Active	☐ Inactive
________________	☐ Active	☐ Inactive	________________	☐ Active	☐ Inactive
________________	☐ Active	☐ Inactive	________________	☐ Active	☐ Inactive
________________	☐ Active	☐ Inactive	________________	☐ Active	☐ Inactive
________________	☐ Active	☐ Inactive	________________	☐ Active	☐ Inactive
________________	☐ Active	☐ Inactive	________________	☐ Active	☐ Inactive

DOCUMENTATION NEEDED FOR ENDORSEMENT APPLICANTS:

YOU must send an "Interstate Verification Form" to each state in which you are, or ever have been, licensed (Make copies as needed) *(See page 10).*

11. Criminal Convictions

Respond to the question at the top of the section, then list any criminal conviction(s) in the space provided.

If necessary, you may continue on a separate 8½ x 11 sheet of paper.

Have you ever been convicted of a violation, plead Nolo Contendere, or entered a plea bargain to any federal, state or local statute, regulation, or ordinance or are any formal charges pending? ☐ Yes ☐ No

Abbreviation of State and Conviction[1] (e.g. CA - Illegal Possession of a Controlled Substance):

	Month	Year
_____	☐☐	☐☐
_____	☐☐	☐☐
_____	☐☐	☐☐

12. Disciplinary Questions

Check either Yes or No for each question.

NOTE: If you answer "Yes" to any question, you are **required** to furnish complete details, including date, place, reason and disposition of the matter.

1.	During any Professional/Medical Education, were you ever dismissed, suspended, restricted, put on probation, or otherwise acted against or did you take a leave of absence for medical reasons?	☐ Yes	☐ No
2.	During any Professional/Medical Education, were you ever requested to leave or did you leave, temporarily or permanently, prior to completion of training?	☐ Yes	☐ No
3.	During any training, were you ever dismissed, suspended, restricted, put on probation, or otherwise acted against or did you take a leave of absence for medical reasons?	☐ Yes	☐ No
4.	During any training, were you ever requested to leave or did you leave, temporarily or permanently, prior to completion of training?	☐ Yes	☐ No
5.	Are there any charges or investigations pending, in any state, against you?	☐ Yes	☐ No
6.	Have your staff privileges at any hospital, nursing home, or other health care facility or health care provider or HMO ever been reduced, revoked, or suspended or have you voluntarily surrendered your clinical privileges from any such unit or facility while under investigation in any state?	☐ Yes	☐ No
7.	Have you ever had any disciplinary action(s) taken, or is any pending, against your License to practice medicine, DEA Permit, State Controlled Substances Registration, Medicare Privileges, Medicaid Privileges, or are any complaints pending in any state?	☐ Yes	☐ No
8.	Have you ever had a membership in a professional society revoked, suspended, or limited in any manner or have you voluntarily withdrawn while under investigation?	☐ Yes	☐ No
9.	Have you ever failed to pass an examination for licensure?	☐ Yes	☐ No

Note: If you answer "Yes" to any question, you are **required** to furnish complete details, including date, place, reason and disposition of the matter. You may use the space below or, if needed, on a separate sheet of paper.

13. Affidavit of Applicant

Complete this section and sign in the presence of a notary public.

Make sure that you and the notary public have completed all components accurately and completely.

I, _____, being first duly sworn, depose and say that I am the person referred to in the foregoing application and supporting documents.

I have read carefully the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my license to practice as a Physician Assistant in the State of Rhode Island.

I understand that my records are protected under the Federal and State Regulations governing Mental Health Patient Records and cannot be disclosed without my written consent unless otherwise provided in the law. I understand that my records are protected under the Federal and State Laws and Regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided in the regulations.

I understand that this is a continuing application and that I have an affirmative duty to inform the Rhode Island Board of Licensure of Physician Assistants of any change in the answers to these questions after this application and this affidavit is signed.

_____ _____

Signature of Applicant | Date of Signature (MM/DD/YY)

The foregoing instrument was acknowledged before me this _____ day of _____, 20_____, by _____, who is personally known to me or has produced _____ as documentation and did / did not take an oath.

_____ _____

Name of Notary (Print, Type or Stamp) | Signature of Notary

Notary Seal

_____ _____

Notary No/Commission No. | Commission Expiration Date (MM/DD/YY)

14. Recent Photograph

Securely tape or glue in this square a current 2" x 2" photograph of yourself (alone).

Photographs must be recent, passport type photo, clear, front view, full face without a hat or dark glasses.

Full length photos will not be accepted.

Affix Photo Here

Write your name on the back of the photograph, and provide the date that the photograph was taken.

_____

Date of Photograph

APPLICATION CHECKLIST

Please review the following checklist to ensure that all the components of the application process have been satisfied. Some items may not apply.

Board Application

- ☐ I have read and understand the "Instructions for Completing the Application".
- ☐ I have completed the Rhode Island Board application as instructed (pages 5-8).
- ☐ I have attached the cover page of the application.
- ☐ I have completed Section 13, **"Affidavit of Applicant"**, and had the form notarized by a notary public.
- ☐ I have attached a photograph to Section 14, **"Recent Photograph"** as instructed. I have verified that it meets the photograph requirements as stated in the application.
- ☐ I have a **check** or **money order** (preferred), made payable (in U.S. funds only) to the: ***"Rhode Island General Treasurer"*** in the amount of **$62.50** (or **$162.50 with CSR**) and attached it to the upper left-hand corner of the first (Top) page of the application.
- ☐ I have arranged my Board Application materials in the following order.
    1. Fee (attached as instructed).
    2. Board Application (including cover page) and pages 5-8.
    3. Supporting documentation as required. [**Note:** Pages containing additional information in continuation of the Board application MUST indicate the section for which the information is being reported.]
    4. Mandatory Addendum to License Application (Verification of Social Security Number) page 12
- ☐ I have mailed the above application materials directly to the Rhode Island Board of Licensure of Physician Assistants.

Required Forms

- ☐ I have completed and mailed the following forms as instructed.
    1. Interstate Verification Form(s) - Other State License(s).

Other Documents

- ☐ I have requested a school transcript and my certification or score (NCCPA) as instructed, OR I have contacted **FCVS**.
- ☐ RI Uniform Controlled Substances Act Registration Form (if applicable) CSR Form (page 11.).
- ☐ I have applied to have my credentials verified by the Federation Credentials Verification Service (FCVS).

Substitute forms are not acceptable, copy this form as needed.

Rhode Island Board of Licensure of Physician Assistants
Room 205, 3 Capitol Hill
Providence, RI 02908-5097
(401) 222-3855

INTERSTATE VERIFICATION FORM - OTHER STATE LICENSE(S)

I am applying for a license to practice as a Physician Assistant in the State of Rhode Island. The Rhode Island Board of Licensure of Physician Assistants requires that the following form be completed by the jurisdiction(s) in which I hold or have held a license. This constitutes authority for you to release all information in your files, favorable or otherwise, directly to the Rhode Island Board of Licensure of Physician Assistants at the above address.

Print/Type Full Name _____ Signature _____ Date _____

Previous Names Used _____ Social Security Number _____ Date of Birth _____

License Number _____ Date Issued _____

THIS SECTION TO BE COMPLETED BY THE PHYSICIAN ASSISTANT BOARD

Physician Assistant Program Completed:	**Location:**	**Graduation Date:**

Licensed by Examination? ☐ Yes ☐ No	**Applicant has completed and passed the NCCPA Exam:** ☐ Yes ☐ No

License Status: ☐ Active ☐ Inactive ☐ Lapsed	**Original Date Issued:**	**Expiration Date:**

Questions:

1. Has this licensee ever been investigated by your Board? ☐ Yes ☐ No
2. Has this licensee incurred any disciplinary proceedings in your state, or is any action pending? ☐ Yes ☐ No
3. Has the applicant's license ever been denied, surrendered, reprimanded, suspended, revoked or placed on probation? ☐ Yes ☐ No
4. Do you know of any information that may discredit this person? ☐ Yes ☐ No

If you answer "Yes" to questions 1-4, please provide a written explanation below, and attach a copy of all supporting documentation (e.g., Board order, complaint, etc.).

_____

_____

_____

Certification:

Signature _____ Date _____

Type or Print Name _____

Title _____

Full Name of Licensing Board _____

Please Affix
Board Seal Here

Please return directly to the Board at the above address. Thank you for your prompt cooperation.

Substitute forms are not acceptable - This form may be duplicated as needed.

Rhode Island Board of Licensure of Physician Assistants

Room 205, 3 Capitol Hill
Providence, RI 02908-5097
(401) 222-3855

Rhode Island Uniform Controlled Substances Act Registration (CSR)

I am applying for a Rhode Island Uniform Controlled Substances Act Registration (CSR). **I understand that there is an additional $100.00 fee for this Registration Application (NON-REFUNDABLE) and that the check or money order must be made out to the RI General Treasurer.**

Print/Type Full Name _____ Business Name _____ Current RI PA LicenseNo. _____

Signature _____ Business Address _____ Business Telephone _____

Date _____ Business Fax _____

Complete this application for registration to prescribe controlled substances in the State of Rhode Island

The Rhode Island Uniform Controlled Substances Act can be accessed at the following web Site:
www.rilin.state.ri.us/Statutes/Title21/21-28/index.htm

Drug Schedule (Check all that apply)

☐ Schedule II ☐ Schedule III ☐ Schedule IV ☐ ScheduleV

A CSR is not required if there will be no controlled substances prescriptions prescribed in this state.

The CSR is renewed at the same time as the professional license is renewed.

NOTE:
Read Important Information on the bottom of this application.

A Copy of the DEA Registration must be provided to the Physician Assistant Board within 60 Days of its issuance by the DEA. The DEA Registration must be issued to your Rhode Island Practice Address in order for it to be valid. If you are relocating from another state, you need to apply for a DEA Registration that is specific to Rhode Island. See The bottom of this form for information on how to contact DEA.*

All Applicants MUST answer the following:

A. Has the applicant been convicted of, or entered a plea of nolo contendere to a violation of any state or federal law relating to manufacturing, distributing, possessing, prescribing, administering or dispensing of drugs presently defined as controlled substances under Chapter 21-28, General Laws of Rhode Island? ☐ Yes ☐ No

B. Has the registration application or registration of the applicant, corporation, firm, partner, or officer of the applicant been surrendered, revoked, suspended or denied under any law of the United States or of any state relating to drugs presently defined as controlled substances under Chapter 21-28 of the General Laws of Rhode Island, or is such action pending? ☐ Yes ☐ No

If you answered "Yes" to question "A" or "B" attach an explanation to this form.

Important Information

Issuance of a Rhode Island Controlled Substances Registration is contingent upon registration by the U.S. Drug Enforcement Administration. If denied a "DEA Registration", the Rhode Island Controlled Substances Registration becomes "**VOID**". Licensed drug facilities and licensed practitioners with prescriptive privileges, cannot dispense, possess, store or ship controlled substances in or into the State of Rhode Island without a valid drug facility or professional license. Rhode Island Controlled Substances Registration (CSR), and a federal Drug Enforcement Administration (DEA) Registration. Practitioners may only prescribe, dispense, possess, and store controlled substances within their particular "scope of practice". "Controlled Substances" for purposes of this application, means a prescription drug in Schedules II through V, pursuant to the Rhode Island Uniform Controlled Substances Act, and 21 CFR 1300 of the Federal Code of Regulations. Schedule I drugs are used by researchers, and require the submission of a protocol.

Without a Rhode Island CSR, and federal DEA Registration, licensed drug facilities, and practitioners with prescriptive privileges, may dispense or possess non-controlled prescription medications under its facility or professional license. A CSR will not be granted to an applicant whose BOARD licensure application is "pending" in this state.

A Rhode Island Controlled Substances Registration must be obtained prior to applying for the DEA Registration. Federal regulations require that applicants comply with individual state requirements prior to issuance of a DEA Registration. Once the CSR is issued, applicants must apply to the U.S. Drug Enforcement Administration for a federal registration using that agency's DEA Form 224 (New Application for Retail Pharmacy, Hospital/Clinic, Practitioner, Teaching Institution, or Mid-Level Practitioner). Applicants may apply on-line for the DEA Registration at the following web site: www.deadiversion.usdoj.gov./drugreg/reg_apps/index.html

*You can also receive an application, or check the status of a pending DEA Registration by contacting the Drug Enforcement Administration at the following location: Registration Unit, US Drug Enforcement Administration, JFK Federal Building, 15 New Sudbury Street, Boston, MA 02203-0131, Telephone (888) 272-5174.

NOTE:

- Schedules II, III, and IV of section 21-28-2.08 will become void unless dispensed within thirty (30) days of the original date of the prescription.
- Prescriptions in schedules III, IV and V cannot be written for more that one hundred (100) dosage units and not more than one hundred (100) dosage units maybe dispensed at one time. For purposes of this section, a dosage unit shall be defined as a single capsule, tablet or suppository, or not more than one (1) teaspoon of an oral liquid.
- Prescriptions in schedule II may be written for up to a 30-day supply, with a maximum of two hundred and fifty (250) dosage units, as determined by the prescriber's directions for use of the medication.

Rhode Island Department of Health

3 Capitol Hill, Providence RI, 02908-5097

MANDATORY ADDENDUM TO LICENSE APPLICATION

Tax Payer Status Affidavit / Identity Verification

All persons applying or renewing any license, registration, permit or other authority (herein after called "licensee") to conduct a business or occupation in the state of Rhode Island are required to file all applicable tax returns and pay all taxes owed to the state prior to receiving a license as mandated by state law (RIGL 5-76) except as noted below.

In order to verify that the state is not owed taxes, licensees are required to provide their Social Security Number, or Federal Tax Identification Number (for businesses) as appropriate. These numbers will be transmitted to the Division of Taxation to verify tax status prior to the issuance of a license.

Licensee Declaration

☐ I hereby declare, under penalty of perjury, that I have filed all required state tax returns and have paid all taxes owed.

☐ I have entered a written installment agreement to pay delinquent taxes that is satisfactory to the tax administrator.

☐ I am currently pursuing administrative review of taxes owed to the state.

☐ I am in federal bankruptcy. (Case #_____)

☐ I am in state receivership. (Case #_____)

☐ I have been discharged from bankruptcy. (Case #_____)

_____
Type of Professional/Business License for which you are applying.

_____ _____
Full Name (Please Print or Type) Social Security Number

_____ _____
Signature Phone Number (including area code if not 401)

_____
Date

This form must be completed, signed and attached to your license application for processing.